A Plan for the Delivery of Health Care to the Homeless

A report prepared for
Tarrant County Commissioner
Roy Brooks by

The Blue Ribbon Task Force on Health Care for the Homeless

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EXECUTIVE SUMMARY

Homeless persons face significant barriers to the most basic health needs, such as nutrition, safety, and shelter; and the barriers are even greater when it comes to meeting additional health needs, such as those requiring health services. Having a health care plan in place not only saves money through reducing inefficiency in delivery of care to the homeless, but positions Tarrant County to take full advantage of federal resources to sustain programming. To build on the strategies set forth by the City of Fort Worth, Tarrant County Commissioner Roy C. Brooks established the Blue Ribbon Task Force on Health Care for the Homeless in 2007. The purpose of this brief is to compile the efforts and suggestions of the Task Force in a long-range strategy to deliver comprehensive, high-quality health care to the homeless in Tarrant County. Key to the plan is the creation of a central resource facility (CRF) to provide comprehensive health and support services to the homeless, including screening, clinical acute and chronic disease care, behavioral health services, dental care, podiatric care, and vision care. A secure pharmaceutical distribution system and an electronic record system would also be housed at the CRF. Overall case management to coordinate all aspects of services is needed to facilitate transition out of homelessness; in addition, a medical "navigator" is needed to assist the patient in coordinating all aspects of medical care and navigating the health care system to meet patient needs. The CRF should seamlessly integrate health care delivery with other support services, including life skills training, financial and job counseling, day care, educational opportunities, and housing assistance. A coordinated, community-based approach to implementing the proposed plan is necessary in order to move from a crisis management model to a holistic approach. This document provides a template to guide the adaptation and implementation of a model program in Tarrant County, including direction in the analysis and prioritization of gaps in service delivery and how to develop actionable steps for implementation. Strategic investment in the broader plan to end homelessness will not only improve quality of life for the formerly homeless but also result in a cost savings to the citizens of Tarrant County.

INTRODUCTION

At any given time in Tarrant County, over 4,000 people are homeless, and more than 6,300 individuals experience homelessness in Tarrant County each year (Mayor's Advisory Commission on Homelessness, 2008). A person is considered homeless if (s)he lacks a fixed, regular and adequate nighttime residence; and (s)he has a primary nighttime residence that is:

- A supervised publicly or privately operated shelter designed to provide temporary living accommodations;
- An institution that provides a temporary residence for individuals intended to be institutionalized; or
- A public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for human beings (42 U.S.C. §11302, 2000).

Of the homeless in Tarrant County, nearly one third are children, 1 in 5 are women and children fleeing domestic violence, over 1 in 6 are veterans, and over half have a disabling health condition that largely contributes to their homelessness. Furthermore, in a recent study, 97% of the homeless in Tarrant County reported wanting to escape from homelessness (Mayor's Advisory Commission on Homelessness, 2008).

In fiscal year 2007, homelessness cost Tarrant County over $30 million, while taking a priceless toll on health, security, stability, and quality of life for the individuals and families who experienced life without a home. In a 2008 citizen survey, 9 out of 10 Fort Worth residents reported believing it is important to address homelessness (Mayor's Advisory Commission on Homelessness, 2008). Residents, business owners, and policymakers are motivated and mobilized to address local homelessness to mitigate its economic, political, and social costs.

In response to this collective desire to address homelessness in Tarrant County, the Mayor of Fort Worth established the Mayor's Commission on Homelessness. The Commission was charged with creating a 10-year plan to end chronic homelessness in Fort Worth. In cooperation with local citizens, the Commission subsequently produced "Directions Home: Making Homelessness Rare, Short-term, and Non-recurring in Fort Worth, Texas within Ten Years" (Mayor's Advisory Commission on Homelessness, 2008). The Fort Worth City Council voted unanimously to adopt the plan on June 17, 2008.

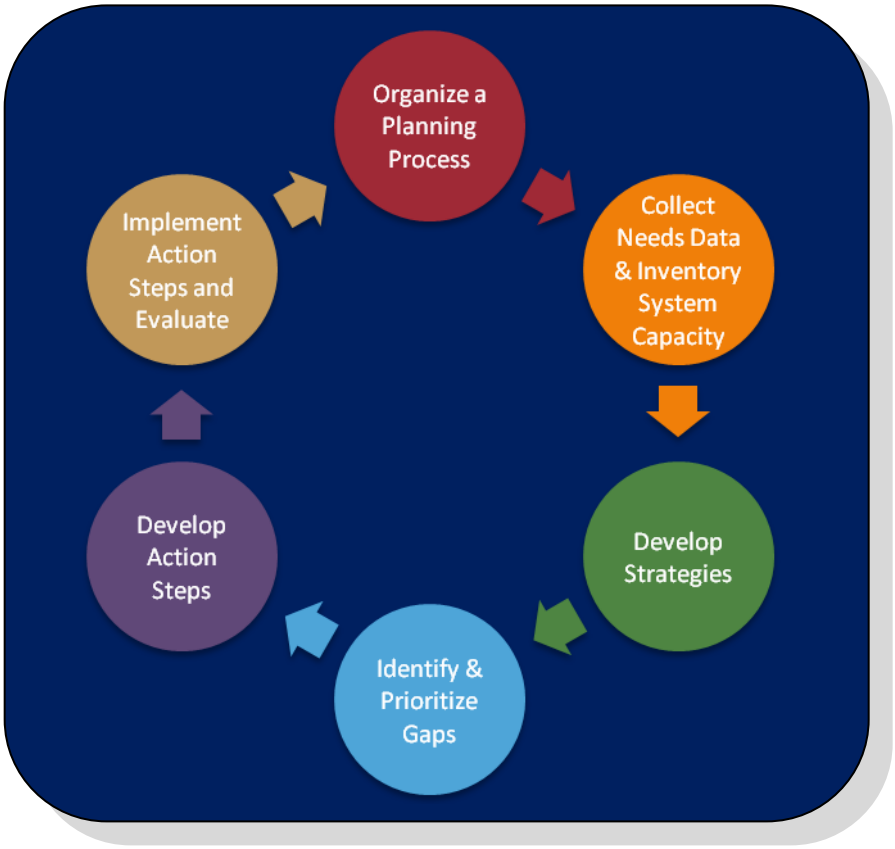
The plan outlines strategies for ending chronic homelessness in Fort Worth. Central to the plan is the strategy set forth to "develop and operate a central resource facility" (Mayor's Advisory Commission on Homelessness, 2008). The facility will provide Fort Worth's homeless population with a common point of access to critical services for health care, stabilization, transition, assistance, and reintegration through provision of individualized case management and primary medical, dental, and mental health services. The facility will serve as the cornerstone to a plan to provide health care to the homeless.

To build on the strategies set forth by the City of Fort Worth, Tarrant County Commissioner Roy C. Brooks established the Blue Ribbon Task Force on Health Care for the Homeless. A full list of Task Force members is provided in Appendix A. The Task Force convened in 2008, meeting over several months, with the following vision:

> *To promote wellbeing and improved quality of life among homeless persons in Tarrant County by assuring access to high-quality, comprehensive health care and support services to facilitate transition out of homelessness.*

As depicted in the first three steps of Figure 1, the Task Force organized a planning process for providing health care to the homeless, assessed the health care needs of the homeless and the current system's capacity to meet those needs, and developed a strategy for improving the current system. The purpose of this brief is to lay out the Task Force's long-range strategy to deliver comprehensive, high-quality health care to the homeless in Tarrant County. The strategy is based on an assessment of community needs and assets and is intended to be comprehensive and collaborative, suggesting proactive solutions to improve the health of the homeless. It will only be successful, however, if it is part of a broader strategy that focuses on ending homelessness.

Figure 1. The Planning Cycle



BACKGROUND

Medical Needs of the Homeless

Health factors commonly contribute to homelessness, but can also result from or are exacerbated by homelessness. Homeless persons are 2 to 6 times more likely to be ill or injured than persons who are housed (Wright, 1990). One study found 43% of homeless people in the United States had either a mental health or substance use problem (Burt, 2001), and 50% of homeless individuals with serious mental illness have a co-occuring substance abuse disorder (National Alliance on Mental Illness, 2008). Homeless populations are at high risk for injuries; skin problems; assault; infectious diseases such as hepatitis, tuberculosis, and HIV; and hypothermia (Kushel, Evans, Perry, Robertson, & Moss, 2003; Tanaka & Tokudome, 1991; Stratigos & Katsambas, 2003; Robertson, et al., 2004; Cheung, Hanson, Marganti, Keeffe, & Matsui, 2002). Homeless children are particularly vulnerable, experiencing twice as many ear infections, five times more gastrointestinal ailments, four times as many respiratory infections, and four times greater likelihood of asthma as housed children (National Center on Family Homelessness, 2008). Moreover, being homeless impedes access to health care and complicates the delivery of health services (Kushel, Vittinghoff, & Haas, 2001). To formulate a plan to effectively deliver health services to the homeless, their health care needs and the barriers they face to receiving health care must be understood.

Health conditions of the homeless either exist prior to, in some cases contributing to, homelessness, or result from homelessness. Whether preexisting or occurring as a result, the health ailments commonly found in the homeless can generally be classified into one of four categories—acute, chronic, communicable, or mental. These categories are described in Table 1.

Table 1. Categories of Health Conditions Commonly Found in Homeless Persons[+]

Category	Prevalence among homeless	Preexisting, resulting from, or exacerbated by homelessness	Examples of conditions commonly seen in homeless
Acute illness	Accounts for approximately two thirds of health conditions with which homeless persons present	Often direct result of homelessness	Respiratory infections, trauma (sprains, lacerations, fractures etc.), skin ailments, dental problems
Chronic physical conditions	Account for approximately one third of conditions with which homeless present	May contribute to homelessness. May also be exacerbated by homelessness due to stress, exposure, and poor access to treatment	Hypertension, gastrointestinal problems, neurological disorders, diabetes, asthma, arthritis, chronic obstructive pulmonary disease, vision problems
Communicable diseases	Approximately 20% of homeless persons have a communicable disease	Serious conditions, like HIV, may contribute to homelessness Often contracted while homeless due to crowded shelters, rape, or exchanging sex for survival needs	Lice, scabies, tuberculosis (TB), respiratory infections, sexually transmitted diseases, HIV/AIDS
Mental and behavioral conditions	An estimated 20% to 25% of the homeless have experienced mental illness* Approximately half of homeless patients with mental illness are dually diagnosed with substance abuse^	Often preexisting and contributing to homelessness However, some conditions, such as depression, may result from or be exacerbated by homelessness	Schizophrenia, depression, bipolar disorder, antisocial personality, borderline personality, substance abuse

+ Unless otherwise referenced, physical disease categories and disease prevalence are based on data collected by the Health Care for the Homeless Demonstration Project, 1985-1987. Data were collected from 63,000 clients in 17 cities. It is considered the best analysis of a large sample of homeless and is still considered to accurately represent health care needs among the population (McMurray-Avila, 2001).

* (Koegle, Burnam, & Baumohl, 1996)

^ (Dennis, Levine, & Osher, 1991)

Barriers to Maintaining Health Faced by the Homeless

Homeless persons face significant barriers to the most basic health needs, such as nutrition, safety, and shelter; and the barriers are even greater when it comes to meeting additional health needs, such as those requiring health services. The barriers to health faced by the homeless are largely out of their control, inherent in the condition of being without a home or regular shelter. McMurray-Avila (2001) lists the following common barriers to health:

- Limited opportunity to eat a healthy diet due to lack of food choices, storage, and refrigeration
- Lack of sleep due to sleeping outdoors or in a crowded shelter and fear for personal safety
- Limited access to basic hygiene, including minimal access to showers, clean clothes, and a need to keep shoes on for long periods of time out of fear that they will be stolen
- Communal eating, bathing, and sleeping in shelters, facilitating the transmission of communicable disease
- Exposure to the elements when living outdoors, increasing the risk for sunstroke, sunburn, frostbite, and hypothermia
- Increased risk of violence, such as assault, rape, or robbery when sleeping on the street or in shelters
- Absence of family or other social support—fleeing domestic violence is a frequent cause of homelessness among women
- Lack of health insurance and inability to afford needed medications
- No place to rest to facilitate recovery when sick as most shelters close during the day

Barriers to Providing Health Care to the Homeless

In addition to barriers to health faced by the homeless, providers face numerous obstacles to providing health care to the homeless. The following obstacles must be considered in creating a plan to provide health services to the homeless:

- Population mobility, presenting challenges in continuity of care and follow-up
- Lower prioritization of medical needs, such as going to medical appointments and medication compliance, due to their need to focus on more basic survival needs, such as food and shelter
- Inability or difficulty for the homeless to keep medications with them due to lack of storage, refrigeration, or fear of victimization due to others' desire for their medication or needles
- Lack of transportation
- Difficulty in finding providers to whom clinicians can refer patients in needs of specialty services
- Challenges in establishing trust with the patient, especially if the patient suffers from a mental health condition

Providing Medical Services to the Homeless

A plan to provide health care for the homeless must address the aforementioned medical needs of homeless patients and barriers to health and health care. As such, a health care plan should include funding, staffing, and implementation strategies for initial screenings, clinical preventive/primary care services for acute and chronic conditions, diagnostic tests, pharmacy service, follow-up methods, and a referral system for specialty care, dental care, mental health, transportation, and social services. These services may be provided from one central facility or they may be provided off-site by partner organizations and coordinated from a central facility.

Case Management

Equally as important to the success of a health care program as the provision of clinical services is the provision of case management. Case managers link homeless individuals and families to services, link service providers, coordinate services, offer support, and advocate for their clients. This creates a "continuum of care," which allows individuals to seamlessly receive the services they need from multiple organizations.

The multiplicity of problems facing someone without housing is too great for one entity to successfully manage. Thus, an interdisciplinary approach is required to provide the array of services needed for homeless persons to realize health, stability, housing, and wellbeing. However, the diverse range of services that may be necessary to help the individual may result in fragmented care if not properly and cohesively coordinated. Furthermore, the services sought may be difficult to access. Therefore, case management is critical to successfully linking homeless persons with the variety of services they need, and to cohesively managing those services so they may achieve their desired outcomes.

Recordkeeping

Another non-clinical, yet essential, element to consider in constructing a health care plan is centralized recordkeeping. A central database will maintain a record of health care for each patient, allowing reports to be generated to show demographic information, conditions treated, and health services provided. Such recordkeeping is necessary for two reasons: 1) It facilitates efficient health care delivery, reducing duplication of services by serving as a "medical home;" and 2) It gathers data needed to guide understanding of client needs and to report to funding entities. Ideally, this system should be electronic, and each client should be assigned a special code used across a network of services to allow for unduplicated data. That is, health care and support service provider staff would complete an encounter form for each face-to-face visit with a client, and all staff should have access to the system. This further relieves clients from having to repeat historical information during each encounter.

A second critical component of recordkeeping is a central repository for homeless persons to store important documents and identification records. This repository should be co-located with the central database containing medical information.

Medical Outreach

Outreach is necessary to provide health care to those who need it but who are not receiving services. "Outreach," within the context of connecting homeless persons to health care, can be defined as "contact with any individual, who would otherwise be ignored (or unserved) . . . in non-traditional settings for the purposes of improving their mental health, health, or social functioning or increasing their human service and resource utilization" (Morse, 1987). That is, outreach efforts among the homeless are broad, seeking to connect homeless persons with a wide range of health care services based on their needs, rather than only targeting a single group or condition.

A varied approach to outreach among the homeless is necessary because of the wide scope of conditions and populations encompassed within a homeless population, and because of the numerous reasons homeless persons may not be in receipt of services. Veterans with post-traumatic stress disorder, women and children fleeing domestic violence, persons with HIV/AIDS, and individuals suffering from mental illness or battling substance abuse are a few of the varied groups susceptible to homelessness. Within these disparate groups are many reasons why persons in need are not connected to services. Such reasons include lack of awareness of need for care or availability of care, fear of obtaining care due to negative past experiences or paranoia linked with mental illness, and avoidance of places providing care due to fear of being found by abusers (McMurray-Avila, 2001). Outreach is critical to connecting these individuals with appropriate health care, to improve their physical and mental functioning, and thereby fulfill an essential step in facilitating the process of transitioning persons out of homelessness.

Outreach efforts may operate from one location outside of the traditional medical setting, from mobile efforts, or a combination of both. Services provided during outreach may be provision of information or referral, or may be the direct provision of medical services (McMurray-Avila, 2001).

Referral Services and Staffing

Establishing an extensive, reliable referral network is necessary to provide the comprehensive array of services needed by a homeless population. The referral network includes both referrals from a central health care facility to other providers or organizations, as well as referrals made to a central facility from other entities. In creating a centralized plan for health care delivery to the homeless, collaborative approaches to providing services must be well-organized and well-established. Plans must be made regarding which organizations will provide their services on-site at a central facility and which will provide services off-site, as well as a system for transportation to off-site services. For on-site

services, plans among different providers for sharing space, office equipment, and support staff should be determined. An approach to staffing programs must also be set forth. McMurray-Avila (2001) offers the following examples of staffing options:

- Each partner takes responsibility for a particular service provided on-site. Staff report solely to their own organization.
- Contract for staff from other organizations to work at the facility to serve as facility team members.
- Contract with an organization to provide the service as needed, off-site at their own facility.
- Contract with an organization to provide the service off-site, but contract for a set of services or time devoted to only caring for referrals from the central facility (e.g., contracting for a predetermined number of mental health or substance abuse beds, only to be filled by central facility referrals).

Model Plans in Providing Health Care for the Homeless

There are several concerted efforts to provide comprehensive health care services to the homeless populations across the country from which Tarrant County may learn. Below, four successful programs are briefly described, serving as models to guide the adaptation and implementation of such a program in Tarrant County. Table 2 summarizes the salient points from each program.

Boston Health Care for the Homeless Program

The City of Boston, Massachusetts, established the nation's first health care program designed to fit the needs of the homeless population. Boston Health Care for the Homeless Program (BHCHP) is the most comprehensive and largest health care program for the homeless in the United States. Established in 1985, the BHCHP includes a staff of over 250 health care and social professionals, including doctors, nurses, social workers, mental health counselors, dental hygienists, maintenance and administrative staff, and food service workers. Health care professionals include teaching faculty from local universities. Although several hospitals and shelters throughout the city serve as clinical sites for the homeless, the BHCHP has established a permanent headquarters facility. This central facility includes examination rooms as well as a pharmacy, dental clinic, and outpatient services to the homeless community.

Healthcare for the Homeless, Houston, TX

Healthcare for the Homeless—Houston (HHH) originated from the SEARCH Homeless Project in Houston and the Baylor College of Medicine. In 2001, HHH became an independent nonprofit organization. Services include shelter clinics, a dental program, a pharmaceutical distribution system, and medical outreach on the streets. Additionally, HHH conducts several research studies in implementation of health care services. An electronic medical record system was implemented to deliver efficient, organized care. Student volunteers from the Baylor College of Medicine, University of Texas Health Science Center-Houston, and the University of Houston College of Pharmacy and Graduate School of Social Work evaluate and care for clients under faculty supervision.

The Health Care for the Homeless Network, King County and Seattle, WA

Developed in 1985, the Health Care for the Homeless Network brings together multiple community-based agencies to provide health services to homeless adults, families, and youth. The Network is a decentralized program and dispatches care providers to work with their clients in over 60 locations throughout King County. The Network also provides dental and health services directly to the homeless and formerly homeless population through public health centers. Further, the Network provides health promotion and disease prevention training and assistance for community-based agencies who work with the homeless population.

Denver Housing First Collaborative

This program was created in 2003 by the Colorado Coalition for the Homeless in order to improve health and increase residential stability among Denver's homeless. The program includes housing and support services to chronically homeless individuals with disabilities. The Collaborative emphasizes the connection of their programs with fiscal

responsibility, and the activities were evaluated in 2006 by examining the health and emergency service records of a sample of chronically homeless participants for the 24-month period prior to entering the program and 24-month period after entering the program. The results indicated significant reduction in use of emergency services and improvement in health:

- Total emergency-related costs decreased by 73%
- Total emergency-related cost savings averaged $31,545 per participant
- Inpatient costs were decreased by 66%
- Detoxification visits decreased by 82%
- Incarceration days were reduced by 76%
- 52% reported improved health status
- 43% reported improved mental health status

Denver's Stout Street Clinic has been integral to the Collaborative's success through efforts to improve the health of homeless persons and thereby facilitate their transition to residential stability. The clinic has received national accolades for its comprehensive provision of primary medical, mental, pediatric, prenatal, dental, vision, and pharmacy services. Care is provided to approximately 100 patients each day through an integrated health care team of doctors, nurses, physician's assistants, nurse practitioners, medical assistants, outreach workers, substance abuse counselors, and case managers. The clinic's pharmacy fills over 300 prescriptions each day at no cost to patients.

Table 2. Model Plans Summary Table

Location	Funding source(s)*	Services provided
Boston, MA	• Robert Wood Johnson Foundation • Pew Charitable Trust • Kresge Foundation • Private corporation donations	• HIV/AIDS services • Dental care • Medical respite care • Mental health services • Hospital- and shelter-based clinics • Street outreach services • Family outreach • Central resource facility including 104 inpatient beds, primary care clinic, dental clinic, outpatient mental health services, pharmacy
Houston, TX	• Swalm Foundation • Cathedral Health Ministries • The Medallion Foundation • Outreach Council of St. Luke's United Methodist Church • The Lyons Foundation • Henry Schein Care • Personal/ private donations	• Shelter-based clinics • Dental care • Centralized pharmaceutical distribution system • Street outreach services • Electronic medical records • Medical, pharmacy, social work student volunteers
Seattle, WA	• Robert Wood Johnson Foundation • Pew Charitable Trust • U.S. Department of Housing and Urban Development • U.S. Department of Health and Human Services • City of Seattle • King County • Private foundations and individual donors	• Tuberculosis outreach • Homeless youth medical clinics • Medical respite program • Shelter-based medical services • Street outreach • HIV screening • Family planning services • Podiatric services • Specialty health services • Needle exchange program • Case management • Substance abuse services
Denver, CO	• U.S. Department of Housing and Urban Development • U.S. Department of Health and Human Services • U.S. Department of Veterans Affairs	• Intensive case management team • Substance abuse treatment • Psychiatric evaluation • Medication management • Mental health care • Integrated support services

* Funding includes initial and sustaining sources

COST OF HOMELESSNESS IN TARRANT COUNTY

A conservative estimate reports that Tarrant County spent $30,918,884 on homelessness in 2007. Two thirds of that amount was spent reactively on homelessness and one third was spent proactively (Mayor's Advisory Commission on Homelessness, 2008). Spending a greater proportion of funds proactively, rather than reactively, reduces costs and potentially realizes cost-savings.

Spending taxpayer dollars reactively is inefficient and not cost-effective. Approximately $5,595,771 in local tax dollars has been spent reactively on the health care costs of the homeless in the past two years. In 2007 alone, the 10 most expensive homeless patients at the John Peter Smith Hospital cost taxpayers more than $508,034, and tuberculosis and sexually transmitted diseases surveillance among the homeless cost over $500,000 in taxes (Mayor's Advisory Commission on Homelessness, 2008). MedStar ambulance service and the Fort Worth Fire Department responded to 3,128 9-1-1 calls to only four homeless shelters in 2007 (Mayor's Advisory Commission on Homelessness, 2008). Many of those calls were made due to health emergencies resulting from a lack of primary care and may have been prevented with inexpensive primary care visits and/or access to medications.

Proactively addressing the health care needs of the homeless, in particular, affords Tarrant County a realistic means to save local money. By proactively coordinating health care for the homeless through a central plan, a more seamless continuum of care is realized, thereby reducing inefficiencies otherwise resulting from duplication of services or preventable health emergencies. Data from other states support the cost savings of implementing a coordinated system of case-managed care for the homeless. According to a 2003 report from Minnesota, one plan resulted in a reduction of crisis costs of $6,200 per family, and a shift to supportive and preventive services. Another 2003 Minnesota report indicated that the median cost of health care was reduced from just over $9,000 per year per homeless individual to just over $5,000 (Minnesota Department of Human Services, Department of Corrections, and Housing Finance Agency, 2004).

While an initial investment on the part of Tarrant County exists to build capacity for a central plan to provide health care to the homeless, long-term local cost-effectiveness will be realized through the use of federal funds to sustain local benefits. In July 2000, the federal government set forth a goal to end chronic homelessness within 10 years. The U.S. Department of Housing and Urban Development and U.S. Department of Health and Human Services subsequently have greater amounts of funding available to communities seeking to sustain plans to end chronic homelessness. Having a health care plan in place not only saves money through reducing inefficiency in delivery of care to the homeless, but positions Tarrant County to take full advantage of federal resources to sustain programming, such as the Health Care for the Homeless Program, administered by the Health Resources and Services Administration. **An important goal of this brief is to increase competitive advantage for receiving this type of federal support.**

RESOURCE INVENTORY

As previously described, one of the key goals of the Tarrant County Blue Ribbon Task Force on Health Care for Homeless was to compile an inventory of existing system capacity dedicated to serving the Tarrant County homeless population. Table 3 lists the organizations that were included in the inventory and their purposes according to their respective web sites.

Table 3. Tarrant County Organizations Providing Health Care Services to the Homeless

Organization	Type	Purpose
Albert Galvan Health Clinic	Nonprofit Federally Qualified Health Center	Provides primary care to all, regardless of ability to pay
Catholic Charities	Nonprofit	Provides services to the needy
Fort Worth Public Health Department	Public	Promotes and protects the health of Fort Worth's citizens
Cook Children's Medical Center	Nonprofit	Provides pediatric health care
Cornerstone Assistance Network	Nonprofit	Provides assistance to help those in need become financially stable
Day Resource Center	Nonprofit	Provides daytime facilities and resources for the homeless
Helping Restore Ability	Nonprofit	Provides assistance for physically disabled persons
John Peter Smith Health Network	Public	Delivers health care to Tarrant County residents
Mental Health Mental Retardation of Tarrant County	Public	Delivers mental health services to Tarrant County residents
Presbyterian Night Shelter	Nonprofit	Provides free night shelter and care for homeless persons
Recovery Resource Council	Nonprofit	Provides care to overcome substance abuse for Tarrant and surrounding counties
Tarrant County Homeless Coalition	Nonprofit	Provide leadership in the prevention and eradication of homelessness
Tarrant County Public Health Department	Public	Provides public health services to Tarrant County
Tarrant County Medical Society	Nonprofit	Provides a supportive practice environment for all physicians and fosters quality health care for the people of Tarrant County
Texas Christian University	Private	Provides education to nursing and social work students
Union Gospel Mission of Tarrant County	Nonprofit	Provides transitional housing and services for homeless persons
United Way	Nonprofit	Coordinates a network of essential services
University of North Texas Health Science Center	Public	Educates medical and health science professionals; provides primary care; conducts research; and engages in community outreach

Table 4 contains the health services provided by these organizations. These services are characterized by the elements recommended for inclusion in a health care plan for the homeless (McMurray-Avila, 2001). Table 5 compiles the health support services provided by these organizations. These support services are also critical to the success of a comprehensive health care program for the homeless.

Table 4. Health Services Provided by Partner Organizations

Health Services Provided	Albert Galvan Health Clinic	Catholic Charities	Cook Children's Medical Center	Cornerstone Assistance Network	Day Resource Center	Fort Worth Public Health Department	JPS Health Network	MHMR of Tarrant County	Presbyterian Night Shelter	Recovery Resource Council	Tarrant County Homeless Coalition	Tarrant County Public Health	Tarrant County Medical Society	TCU School of Nursing	Union Gospel Mission of Fort Worth	UNTHSC
Behavioral health services			X*				X	X								
Chronic disease screening	X		X*	X			X					X				X
Chronic disease treatment	X		X*				X					X				X
Dental health services				X			X									
HIV counseling/case management		X					X	X				X				
HIV testing			X*				X					X				
HIV treatment			X*				X					X				
Laboratory services	X		X*				X									
Medical case management	X		X*		X		X									X
Mental health services			X*				X	X								
Nursing student volunteer providers														X		
Ophthalmological services				X												
Pediatric acute care	X		X*				X									
Perinatal care			X*				X									X
Perinatal counseling		X				X	X									
Pharmacy services		X	X*	X			X									
Preventive women's health services	X						X					X				
Radiology services			X*				X									
Referral to services	X		X*		X		X	X	X	X	X		X		X	
Respite beds								X	X							
STD screening and treatment	X						X					X				X
STD/HIV outreach							X	X				X				
Substance abuse services								X		X						
TB screening & active TB treatment	X						X					X				
Treatment of acute illness/injury	X		X*				X									X
Well-child check-ups	X		X*				X									
Women's health/family planning	X						X									

* = Services only provided to children

Table 5. Health Support Services Provided by Partner Organizations

Health Support Services Provided	Cook Children's Medical Center	Cornerstone Assistance Network	Fort Worth Public Health Department	Helping Restore Ability	MHMR of Tarrant County	Presbyterian Night Shelter	Recovery Resource Council	Tarrant County Homeless Coalition	Union Gospel Mission of Ft. Worth	United Way
Cancer support services										X
Centralized recordkeeping						X*~^				
Daily living skills assistance	X*			X¥	X	X*~^				
Emergency food and clothing						X*~^				X
Health education and health promotion	X*		X			X*~^				
HIV/AIDS support services										X
Overall case management	X*			X¥	X	X*~^	X±			
Referral to services	X*		X	X¥		X*~^	X	X	X	X
Temporary/transitional housing		X			X	X*~^			X	X
Transportation to appointments	X*					X*~^				

¥ = Services only provided for the physically disabled
± = Services only provided for substance abuse/HIV dually-diagnosed
* = Services only provided to children and/or families with children
~ = Services only provided for the mentally ill
^ = Services only provided for veterans

Based on the documented services, it appears that the following services are still needed:

- Overall case management
- Centralized recordkeeping
- Laboratory services
- Radiology services
- Pharmacy services
- Transportation
- Respite Beds

In order to have a more refined estimate of the gaps in existing services and to provide robust evidence to support policy and programmatic recommendations, it will be important to engage in a gap analysis. Appendix B provides instructions and a worksheet to engage in a gap analysis.

RECOMMENDATIONS

Successful health care programs designed to meet the needs of the homeless population in the United States comprise not only a comprehensive medical care plan, but also a broad partnership with all the stakeholders: hospitals, churches and faith-based organizations, prisons, nonprofit organizations, etc. In Tarrant County, health care for the homeless should be addressed with a comprehensive medical plan in partnership with stakeholders. The plan should include the following elements:

- A central resource facility (CRF) to provide comprehensive health and support services to the homeless. The CRF should seamlessly integrate and co-locate health care delivery with other support services, including life skills training, financial and job counseling, day care, educational opportunities, benefits eligibility and enrollment, and rapid re-housing assistance. Models that have used a decentralized approach to providing health care services have documented inherent challenges, such as not having private spaces for providers to meet confidentially with clients.
- Services to include initial screenings, clinical preventive/primary care for acute and chronic health conditions, as well as diagnostic testing capability, mental health services, dental care, podiatric care, and vision care. Off-site primary and specialty care for special populations such as children will be accessed in the community, when available.
- Overall case management to coordinate all aspects of services needed to facilitate transition out of homelessness.
- A medical "navigator"—i.e., a medical case manager—is also needed to assist the patient in coordinating all aspects of medical care and in navigating the health care system to meet patient needs. The medical navigator connects the patient with a medical home outside of the CRF after the patient moves to transitional housing. The overall case manager and the medical navigator must work together to meet patient needs in order to seamlessly receive multifaceted care.
- A firm, structured schedule for when the CRF is open and services are available. Homeless persons rely largely on word-of-mouth and must know when to expect services to be available.
- Access to basic hygiene needs. Responsibility for this must be designated. Medical care alone is insufficient without basic hygiene.
- A secure pharmaceutical distribution system located at the CRF, including considerations regarding storage, refrigeration, use of medications for bartering, and fear of victimization for medications or needles.
- A continuum of care plan that takes into account the mobility of the population and their barriers to accessing care.
- A designated entity for providing transportation services and for scheduling its use.
- A wide, reliable referral network, including a comprehensive array of specialists to whom patients can be referred. All agreements for referrals and staffing should be set forth in written contracts and should explicitly state expectations for parties involved.
- Increased awareness among providers of the importance of the patient-provider relationship to overcoming the fear and distrust that exists among some homeless persons towards health care providers. Establishing trust is essential to working towards a continuum of care.

- A centralized electronic records database to provide efficient care and a repository for important client documents.
- Street engagement and outreach in order to reach the homeless and create awareness of the services and benefits they can access at the CRF.
- Ongoing outreach to targeted communities, especially within Arlington and Fort Worth.
- Health education, health literacy, and wellness services.
- A research agenda for health care for the homeless.
- Evaluation of Tarrant County's progress in implementing a plan to provide health care for the homeless.

CONCLUSIONS & NEXT STEPS

The purpose of this brief is to propose a strategy for a comprehensive, quality health care system for the homeless in Tarrant County. Several community partners, including the John Peter Smith Health Network, Mental Health and Mental Retardation of Tarrant County, Cook Children's Health Care System, Recovery Resource Council, and others have already committed significant efforts to meet the recommended components of the plan, but much work remains.

According to Figure 1, the next step in the process of planning for a health care delivery system for the homeless is to identify and prioritize the gaps, and community involvement is essential to determining priority areas. General directions for identifying gaps, along with a Gap Analysis Worksheet, are provided in Appendix B. Based on the findings from the gap identification/prioritization process, and grounded in the strategy laid out in this brief, the final steps are to develop short- and long-term action steps that will link identified gaps with possible resources, assign responsibilities, and develop time frames. Questions to consider in drafting these action steps are shown in Figure 2, and an Action Plan Worksheet is given in Appendix C.

Figure 2. Guidance for Action Steps

Questions to Help Draft Action Steps

- Is there an opportunity, project, or activity that will be lost if not begun immediately?
- Is there a timing issue where one action step is necessary before others can be taken?
- Is the amount of effort needed to undertake the activity reasonable?
- How critical is this strategy?
- Is the proposed activity feasible?
- Are there major barriers to implementing this activity?

U.S. Department of Housing and Urban Development, 2007

Certainly, funding is of paramount importance to translating this strategy into actionable steps. As previously mentioned, a principal goal of the development of this plan is to increase competitive advantage for receiving additional funding sources. Although not intended to serve as an exhaustive list, Appendix D is a compilation of available resources to support the recommended program components. Model health care for the homeless programs have demonstrated that diversified funding streams, including both public and private funding sources, are necessary for successful sustainability. Finally, a process must be established to routinely evaluate the Tarrant County Health Care for the Homeless Plan in order to provide guidance for the continuous improvement of programs to improve the health of homeless people.

The Denver Housing First Collaborative found an average reduction of emergency costs among program participants of $31,545. Using a conservative estimate for health care savings for a chronically homeless individual of $10,000 per year, and given that the current estimate of the Tarrant County chronically homeless population is 1,000 individuals (Mayor's Advisory Commission on Homelessness, 2008), this would translate to $10 million in reduced expenses associated with these services. If Fort Worth had a homeless program budget similar to that of a city of comparable size such as Denver (approximately $5 million in 2007) this would result in a cost savings of $5 million.

This document focuses on a plan to deliver comprehensive, quality health care services to the homeless population. But such a plan will never be successful unless it is one part of a broader strategy to provide stable housing and essential support services to this population. The recommendations provided herein as well as the process outlined in Figure 1 should serve to stimulate further action by key stakeholders, most of which are represented by the Blue Ribbon Task Force on Health Care for the Homeless. The extent to which the plan achieves its goals will largely depend on leadership and commitment from elected officials, the John Peter Smith Health Network, the organizations listed in Table 3, and other organizations, including private corporations and individual citizens, which are not identified in this document.

Homelessness places a severe emotional and social strain not only on the individuals who are directly affected but also on society at large. The cost of serving the homeless in a fragmented system designed in a stop-gap, reactionary model versus a proactive, long-term approach is fiscally irresponsible. A coordinated, community-based approach to implementing the proposed plan is necessary in order to move from a crisis management model to a holistic approach. Strategic investment in the broader plan to end homelessness plan will not only improve quality of life for the formerly homeless but also result in a cost savings to the citizens of Tarrant County.

ACKNOWLEDGMENTS

We gratefully acknowledge the valuable contributions to this document by Gail Clark, Hannah Jackson, Natalie Cole, Deepak Prabhakar, Terri Mason, Mieshia Beamon, and Jesse Porter from the Center for Community Health; and by Otis Thornton from the Mayor's Commission on Homelessness. We further thank the members of the Tarrant County Task Force on Health Care for the Homeless Task for their valuable input from which these recommendations arose. Finally, we wish to recognize Fort Worth Mayor Mike Moncrief and Tarrant County Commissioner Roy C. Brooks for their leadership in seeking to eradicate homelessness.

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This document can be accessed online at: http://www.centerforcommunityhealth.org/

APPENDICES

APPENDIX A

Blue Ribbon Task Force on Health Care for the Homeless Members

Organization	Representatives
Albert Galvan Health Clinic	Eddy Herrera
Catholic Charities	John Richardson
City of Fort Worth Public Health Department	Dan Reimer
City of Fort Worth	Kate Scott-Ward M. Otis Thornton
Cook Children's Medical Center	Rich Goode Ginny Hickman
Cornerstone Assistance Network	Mike Doyle
Fort Worth Day Resource Center for the Homeless	Bruce Frankel
Helping Restore Ability	Vicki Niedermayer
John Peter Smith Health Network (JPS)	Joane Baumer Robert Early Adonna Lowe Ron Stutes Wayne Young
Mental Health Mental Retardation of Tarrant County (MHMRTC)	Susan Garnett Artie Williams
Presbyterian Night Shelter	Carol Klocek
Recovery Resource Council	Eric Niedermayer
Tarrant County Commissioners Court	Commissioner Roy C. Brooks Judge Glen Whitley
Tarrant County Commissioner Brooks' Office	Krystal James Cathy Young
Tarrant County Community Development	Patricia Ward
Tarrant County	Carolyn Sims
Tarrant County Homeless Coalition	Cindy Crain
Tarrant County Human Services	Gerald Smith
Tarrant County Judge's Office	Jane Sanford
Tarrant County Public Health Department	Gerry Drewyer
Texas Christian University (TCU) School of Nursing	Melissa Sherrod
Union Gospel Mission of Fort Worth	Don Shisler
United Way	Ann Rice
University of North Texas Health Science Center (UNTHSC)	Kathryn Cardarelli Sue Lurie

APPENDIX B

Gap Analysis

A gap analysis begins with two questions—"Where are we currently?" and "Where do we want to be?"—and seeks to bridge the gap between the findings from those questions. This process provides insight about the remaining resources needed to create a health care delivery system for the homeless. Gaps should be identified according to types of health services needed for the homeless population in the continuum of care and by sub-populations with specific health care needs. In applying gap analysis to the provision of health care for the homeless, the gap, or unmet need, is determined by assessing the current number in need and subtracting the current capacity to serve.

Quantitative Gaps Analysis

Number of Sub-Population in Need - Current Capacity to Serve = Unmet Need

A detailed Gap Analysis Worksheet is included in Appendix B. The following questions may be applied when prioritizing addressing unmet needs:

- What groups are without any resources to serve them compared to groups with some resources available?
- What is the relative need among sub-populations?
- How vulnerable is the population, with consideration given to factors such as age and diagnosis?
- How quickly is the need growing?
- Who are the users of the needed service?

Gap Analysis Worksheet

	Identified Gaps	Estimated Need	Current Inventory	Unmet Need	Relative Priority: Low, Medium, High
Example	*Intensive residential*	***115***	***89***	***26***	***M***
Beds/Units	Intensive residential				
	Inpatient				
	Detoxification services				
	Residential psychiatric treatment				
	Other				
Estimated Service Slots	Chronic disease screening & treatment				
	Daily living skills assistance				
	Dental health services				
	Emergency food and clothing				
	Health education				
	HIV testing, counseling, case management, & treatment				
	Laboratory services				
	Medical case management				
	Mental & behavioral health services				
	Overall case management				
	Perinatal care/counseling				
	Pharmacy services				
	Primary care				
	Radiology services				
	Referral to services				
	STD screening, treatment, & outreach				
	Substance abuse services				
	TB screening & active TB treatment				
	Temporary/transitional housing				
	Transportation to appointments				
	Treatment of acute illness/injury				
	Women's health/family planning				
Estimated Sub-Populations	Chronic Substance Abusers				
	Seriously Mentally Ill				
	Dually Diagnosed				
	Veterans				
	Persons with HIV/AIDS				
	Children/Youth				
	Battered/Abused Persons				
	Re-entry				
	Elderly				
	Persons with Physical Disabilities				
	Other				

APPENDIX C

Action Plan Worksheet

Strategy Statement _____

_____

_____

Gaps to be Impacted	Description/ Components of Strategy

Action Steps	Timeline	Outcomes

Proposed Responsibilities	Lead

Resources Required for Implementation	Potential Barriers to Strategy

APPENDIX D

Potential Funding Sources

Most funding needs fall into one of three basic categories: money, goods, and services. Funding potentially comes from a combination of four sources: public funding, private funding, patient revenue, and private donations (McMurray-Avila, 2001). After establishing what needs exist through the strategic planning process, plans for securing and utilizing funds should be stated in the strategic development plan. In response to needs, funding sources may have very specific health care and/or population aims, such as mental health or children's dental care, or may be quite broad and leave discretion in spend to the recipient. Though the administrative process is challenging, funding is most sustainable when it comes from several different of sources.

Potential Funding Sources

Public Funding

- **U.S. Department of Health and Human Services**
  http://www.hhs.gov/homeless/grants/index.html
  - **Office of Grants Management** (www.hhs.gov/grantsnet/)
  - **Bureau of Primary Health Care—Health Care for the Homeless (HCH)** (www.bphs.hrsa.gov)
    - Grants to establish community health centers for the homeless
    - Funding opportunities for providers of health care services to the homeless
  - **Substance Abuse and Mental Health Services Administration,** Center for Mental Health Services Homeless Programs Branch (http://mentalhealth.samhsa.gov/cmhs/homelessness/about.asp)
  - **Pharmacy Affairs and 340B Pricing Program** (http://www.hrsa.gov/opa/introduction.htm)
  - **Programs for Runaway and Homeless Youth** (http://www.hhs.gov/homeless/grants/index.html)
  - **Street Outreach Program for Youth** (http://www.hhs.gov/homeless/grants/index.html)
  - **HIV/AIDS Program for the Underserved** (http://hab.hrsa.gov/default.htm)
- **Health Care for the Homeless Information Center** (www.prainc.com/hch)
- **National Coalition for Homeless Veterans** (http://www.nchv.org/about.cfm)
- **U.S. Department of Veterans Affairs** (http://www1.va.gov/homeless)
- **U.S. Department of Housing and Urban Development** (http://www.hud.gov/homeless/index.cfm)

Private Funding

- **Foundations On-Line (directory of charitable grant makers)** (www.foundations.org)
- **The Chronicle of Philanthropy** (www.philanthropy.com)
- **The Foundation Center** (www.fdncenter.org)
- **Robert Wood Johnson Foundation** (www.rwjf.org)

- **Pew Charitable Trust** (www.pewtrusts.org)
- **Kresge Foundation** (www.kresge.org)

Patient Revenue

Though most homeless patients will qualify to pay zero costs on a sliding fee scale, the process of evaluating a patient's ability to pay should include consideration of possible Medicaid or Medicare reimbursement.

In-Kind Resources

- **Office of Drug Pricing—Bureau of Primary Health Care**
  For information on pharmaceutical programs
  (800) 628-6297
- **Pharmaceutical research and manufacturers of America (PhRMA)**
  Contact for Directory of Prescription Drug Patient Assistance Programs
  (www.phrma.org)